

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 1 - 0 0 5

2. STATE:

Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES4. PROPOSED EFFECTIVE DATE
July 1, 20015. TYPE OF PLAN MATERIAL (*Check One*):☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENTCOMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.40; 42 CFR 483.12

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 0b. FFY 2002 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-C

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

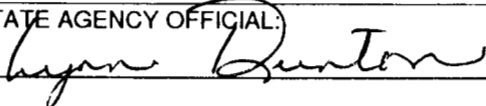
Attachment 4.19-C

10. SUBJECT OF AMENDMENT:

Payments for Reserved Beds

11. GOVERNOR'S REVIEW (*Check One*):☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Lynn Dunton

14. TITLE:

Assistant Director

15. DATE SUBMITTED:

April 25, 2001

16. RETURN TO:

AHCCCS

Mail Drop 4200

801 East Jefferson

Phoenix, AZ 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

May 7, 2001

18. DATE APPROVED:


7-13-01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Linda Minamoto

22. TITLE:

Associate Regional Administrator
Division of Medicaid

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

PAYMENTS FOR RESERVED BEDS

1. Payment for a reserved bed will not be made in an acute care facility.
2. Payment for a reserved bed may be made in a nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a Residential Treatment Center licensed as a Level I behavioral health facility and accredited by an AHCCCS-approved accrediting body, subject to the following conditions:
 - a. The purpose of the absence is to visit family or friends, to prepare the individual for discharge to community living or for an admission to an acute and/or psychiatric hospital;
 - b. The member's plan of care provides for such an absence when therapeutic leave is utilized;
 - c. The absence does not exceed nine therapeutic leave days and 12 bed hold days per contract year for adults age 21 and older, or a total of 21 days (therapeutic and/or bed hold) for persons under 21 years of age;
 - d. Prior authorization is received from the designee for the Regional Behavioral Health Authority (RBHA) or Program Contractor.
3. Payment shall be denied for any absence that is:
 - a. in excess of these limits;
 - b. for purposes other than those listed; or
 - c. not properly authorized.